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AUTHOR	Hashimoto, Kiyotoshi; Elia, Diane; Chambliss, Catherine
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ABSTRACT

The present study compared attitudes about the causes and optimal responses to mental illnesses of college students attending schools in Japan and in the United States. Independent sample t-tests were performed to assess differences between the national groups in their responses to 22 Likert-format items exploring different aspects of a biophysical versus a sociocultural conceptualization of the etiology of mental illnesses. Comparisons of the Japanese and American groups' scores revealed differences on several of the dependent measures. The American students perceived there as being greater negative stigma associated with mental health problems than Japanese students. The U.S. students reported less willingness to seek treatment themselves or to recommend that a friend with a problem go to a mental health clinic for treatment. Significant differences in attitudes toward treatment were also found. U.S. participants endorsed the behavioral and humanistic etiological models more strongly than their Japanese counterparts, and were less supportive of the psychoanalytic perspective than Japanese students. The American students attributed treatment outcome more to patient than to therapist factors, saw patients as having greater control over their mental problems, and perceived thinking about one's problems as more valuable than the Japanese students. (Contains 12 references and 1 table.) (Author/GCP)

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CROSS-CULTURAL DIFFERENCES IN COUNSELING ATTITUDES: JAPANESE VERSUS THE UNITED STATES STUDENTS

Kiyotoshi Hashimoto, Diane Elia, and Catherine Chambliss, Ph.D.

Ursinus College

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Abstract

The present study compared attitudes about the causes and optimal responses to mental illnesses of male and female college students attending schools in Japan and in the United States. Independent samples t-tests were performed to assess differences between the national groups in their responses to 22 Likert-format items exploring different aspects of a biophysical versus a sociocultural conceptualization of the etiology of mental illnesses. Independent sample t-test comparisons of the Japanese and American groups' scores revealed differences on several of the dependent measures. The American students perceived there as being greater negative stigma associated with mental health problems than Japanese students. Perhaps as a consequence of this concern about discrimination, the U.S. students reported less willingness to seek treatment themselves or to recommend that a friend with a problem go to a mental health clinic for treatment. However, the America students were less likely to see mental health problems as a sign of weakness than the Japanese respondents.

Significant differences in attitudes toward treatment were also found. U.S. participants endorsed the behavioral and humanistic etiological models more strongly than their Japanese counterparts, and were less supportive of the psychoanalytic perspective than Japanese students. The American students attributed treatment outcome more to patient than to therapist factors, saw patients as having greater control over their mental problems, and perceived thinking about one's problems as more valuable than the Japanese students. Consistent with this, the U.S. students emphasized the value of verbal psychotherapy developments more so than medical treatment developments. The American students saw the cause of mental health problems as less genetic than the Japanese students, and reported less use of drugs and alcohol to relieve emotional problems.

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Introduction

All over the world, people seek counseling in order to help them address their mental health concerns. This includes people from all nationalities, who have a wide variety of multicultural and international backgrounds, and who come for counseling for a broad range of reasons, including the need for assistance with personal relationships, and emotional, multicultural, social, and psychological problems or conflicts. In addition to confronting a large diversity of problems, counselors must contend with differences among clients in how they conceptualize both their difficulties and their relevant causal factors. Cultural background contributes to how distinctions are drawn between normality and abnormality, what determinants of dysfunction are emphasized, and which mechanisms are used to promote change. In optimizing the counseling experience, it is important for counselors to understand cultural differences in thinking about both etiology and treatment.

The USA is one of the most advanced nations in the field of psychology. Historically, modern psychology was born in Germany and then primarily developed in the USA. However, even in the most advanced nations, only one and a half centuries ago, the field of psychology was still in the Dark Age. Rather then attribute abnormal behavior to physical or mental disease, people thought that abnormalities were caused by evil powers and due to being possessed by a demon or worshipping the devil. As a result it was common for patients who suffered from mental illnesses to be isolated in jail-like institutions that infringed their rights as humans. Through the 20th century knowledge about the human mind has expanded substantially and psychology has been established as a science. In spite of the development of this field, social stigma and discrimination towards people with mental illnesses still exists.

Even in the USA, people are still very likely to have some prejudice against the people who have mental illness. Most of them will be because of the lack of knowledge about the mental illnesses. In addition, such tendency seems to be promoted by entertainment industry or the mass media such as newspaper or TV. Following are some illustrations of the prejudice and the facts challenging these stereotyped assumptions excerpted from one psychology textbook; *Understanding Abnormal Behavior* (Sue, Sue, & Sue, 2001).

Myth: Mentally disturbed people always act with consistently deviant abnormal behavior. Reality: Mentally disturbed people are not always detectable only by the consistently unusual behavior. There is no clear borderline between normal and abnormal. Even when people are suffering from some form of emotional problems, it is sometimes very hard to detect by their behavior.

Myth: Mental illness is inherited without fail and the cause of mental illness is caused only by genetic factors. If one member of a family has one, other members also will suffer from it. Reality: Although the data are far from conclusive, heredity does not seem to play a major role in most mental disorders, except for some type of mental disorders such as some cases of schizophrenia or bipolar disorder.

Myth: The mentally disturbed people can never recover and will never be able to function normally. Reality: Nearly three-fourths of patients who are hospitalized with

severe mental illness will improve and come to lead productive lives. Many recovered mental patients make excellent employees, and it is often reported that they outperform other workers in attendance and punctuality.

Myth: People will suffer from mental illness because of their weak will. Reality: Many problems stem from situations that are not under the individual's immediate control.

Myth: The mentally disturbed person is unstable and potentially dangerous. Reality. This misperception is encouraged especially by the mass media. Many vicious criminals are labeled "psychopathic" and the media emphasizes the temporary mental illnesses they had once. The thousands of mentally disturbed people who do not commit crimes, do not harm others, and do not do any illegal things are not on the news. Studies indicate that mentally disturbed patients are certainly not always dangerous.

These misunderstandings have caused great distress for many people who have at some time been labeled mentally ill. Former mental patients have to endure social discrimination and are often, unfairly, denied employment. Judgments concerning the employability of mentally disturbed people (Rothaus, Hanson, Cleveland, & Johnson, 1963) and their degree of culpability for driving accidents (Ommundsen & Eklend, in press) varies depending on one's beliefs about the nature of mental health problems. Unfortunately, such stigma may keep former mental patients or those who currently have emotional problems from seeking help.

Problematic attitudes towards mental illnesses do not only come from the lack of knowledge about mental illnesses. The difficulty of mental illness itself also contributes to negative attitudes. There is no clear line between normal and abnormal behavior, therefore, mental illnesses are hard to diagnose properly. In addition, there are theoretical controversies even between eminent psychologists and psychiatrists within a given country. Yamaguchi (2002) states that even Okinawa has its own unique approach that differs from that of both the USA and mainland Japan.

People's attitudes toward those who have mental illness varies as a function of their particular way of thinking about it. Farina and Fisher (1979) found that an individual's thoughts about mental illnesses significantly affect certain important beliefs and behaviors. Individuals exposed to a biosocial orientation placed less value on thinking about the cause and solution to emotional problems, and felt they had less control over mental health problems than individuals exposed to a social-learning orientation. Those receiving education emphasizing a biosocial perspective also tended to use more alcohol or drugs to relieve emotional distress during 4 months following the experiment, and tended to seek help for mental problems less.

The Fisher and Farina data indicated that even only short exposure to one belief about mental illness changed individuals' beliefs and attitudes. Each nation has unique religious and cultural traditions, and people who live there are exposed to theses perspective thoughts about their lives.

There is evidence that attitudes in Japan have not been enlightened by recent psychological research. In Japan, some cruel murders whose suspects are thought to have some type of mental disorders have been reported these years. Some examples of these are the case of Tsutomu Miyazaki, who kidnapped small girls, killed them, and showed symptoms which can be regarded as the symptom of dissociative association

disorder when he was arrested in 1988; the case that one junior high school student killed an elementary school student and cut his head to put it on the wall of a school in 1997; and the case of Mamoru Takuma who invaded an elementally school to kill eight children and injure nineteen others 2001. In the case of the school attack by Takuma, social commentators pointed to outdated attitudes toward mental illness and the social stigma attached to seeking help for mental problems as a possible explanation for the killing (McCurry, 2001). These influences of mass media on common people also happens in every country, but the less knowledge between common people will be able to produce more prejudice. With enough knowledge people will attack the commentators when the commentators made wrong or improper comment. Then commentators feel free to comment whatever they think even when they do not have enough knowledge because of the less attack from the audiences, and their prejudices or misunderstanding will influence the audiences.

Chorlton analyzes that one of the Japanese main problem in the aspect of mental health is the stigma attached to them, a long-held custom of Japanese society. Karen Riley who had lived in Kyoto and had a schizophrenic neighbor, claims that the schizophrenic and her sister, who was stigmatized by association, were solely responsible for their problem: the only sensible solution was to ignore it (Lehavot). Riley points out Japanese old saying "kusai mono ni futa" which means to put a lid on anything smelly.

Some think of mental illness within the family as a "haji" which means social shame (Grimes, 2001). For this reason, the mentally disturbed people try to conceal or ignore their problems. Especially men, who may suffer from alcoholism or family/occupational pressures tend to conceal them because admitting "weakness" and seeking treatment is unimaginable (Lehavot, 2001). When patients actually receive counseling, they may withhold the fact from their families. Therefore even with successful treatments, patients' progress may be hindered by a return to an unsympathetic and uniformed community. They may not only face prejudice from members of the outside society, but also from the member of their own family who cannot stand with the dishonor or humiliation of having the mentally disturbed (Hendry, 1995).

In addition to the stigma which prevents people from seeking help, the Japanese custom of "tatemae and honne" makes it harder for them to seek for help. Tatemae refers to public behavior one will do and honne refers to one's true feeling or desires which are not openly expressed (Sugimoto, 1997). By this custom, even those who seek counseling for mental problems tend to conceal their personal feeling or emotions. Andrew Grimes, a counselor and group therapist in Tokyo, states that even as child, the Japanese have been taught to repress expression of their emotions and beliefs in public and sometimes even in private, when deviating from the group view in order to preserve social harmony and agreement (Grimes, 2001).

The problems are not only from the cultural aspects or unique way of thinking but also from the Japanese mental health system. There is a traditional situation that mentally disturbed people face when the doctors are reluctant to share information with patients or their relatives. In one study, participants (consisting of relatives of patients) maintained that doctors did not fully explain the diagnosis to them. This lack of communication between doctors and patients is common, for almost all participants of this study were not made aware of the diagnosis in the doctors' initial assessment, and

most were not told of it until their relative was in need of hospitalization (Yamashita, 2002).

The Japanese mental health care is still primitive in many respects. Mentally disturbed people are still treated by locking them up, in brutal hospitals, isolated from the society. Of course there have been attempts to reform the system. In 1987, the government passed a law that was supposed to encourage less institutionalization and more community-based care, following the example of countries in the West. Yet nothing seemed to change. Japan has three times as many mental-hospital beds per person as Britain, and seven times as many as the United States. In America, patients stay in mental hospitals, on average, for eight days; in Japan, for more than 400 (Economist, 2001).

More disturbing are the conditions inside these hospitals. Most of them are privately owned, built with soft government loans in the 1960s and 1970s. Under Japanese law, mental hospitals are entitled to only one-third the number of doctors, and two-thirds the number of nurses guaranteed per patient in regular hospitals. The mental hospitals' trade association claims that, because of poor funding, its members barely break even. However, Toshio Fujisawa, former director of a large Tokyo mental hospital says that this is a lie: "They make profits by sacrificing their employees and their patients" (Economist, 2001).

Patients' rights are denied in the hospitals. Access to telephones and other means of communicating with the outside are severely restricted. The patients are totally controlled. Treatment is primitive. Electric shock therapy is sometimes used to calm or punish patients, as are isolation rooms. Newspapers carry reports of patients being beaten, of forced abortions, of hospitals without heat or light, and of patients exploited and made to work in the name of occupational therapy.

If these reports are true, are these problems ignored? One factor may involve the Japanese emphasis on " honne and tatemae" and " haji". In addition, it seems that most people think that people who suffer from mental disease are special (one possibility is that they think the cause of mental disease is genetic and the percentage of people who will have mental illnesses is extremely low) and they will have nothing to do with such problems.

The difference of the attitude towards mental illness between two countries is reflected vividly in the difference between the governments' attitude toward the funding for mental health research. In the fiscal year 1994, a total of $9.2 billion (U.S. dollars) was allocated to research, by the Ministry of International Trade and Industry, the Ministry of Education, Science and Culture (NMSC), and Science and Technology Agency (STA). Until recently, the economic cost of mental health care received little attention. However, biomedical research was allocated only $0.55 billion from NWSC and STA, and $0.7 billion from the Ministry of Health and Welfare (MHW). The total of $1.3 billion for biomedical research is far less than that awarded for nuclear energy ($2.2 billion from STA) and below that for the space industry ($1.5 billion from STA). In contrast, in the USA, $8.5 billion was allocated for health research, and the total funds for energy and space are equivalent to the allocation for health research alone (Takei, 1996). Takei said he surveyed the 1245 papers published in the ten most cited psychiatric journals for 1993. He found that the investigators in 672 papers (54%) had received financial support from research grants; fund-supported rates vary slightly among journals

(range 35-78%). Of these articles, 1.2 % (21papers) were reported by Japanese researchers, of which only six reports indicated that their authors were supported by research. He added that, Japan is now the second richest country in the world but the material affluence does not necessarily mean good quality of life (health). Although we cannot compare the data from different nations directly, his data indicates that the proportion of people in Japan who regard their health as being very good is 9%, which is close to that in the former USSR (3%), whereas this figure is 39% in the UK, and 48% in the USA.

In the present study, it was hypothesized that there will be significant difference in the attitudes toward mental illness between subjects from the USA and Japan. Differences in endorsement of various etiological models were also explored.

Methods

College students from the United States (n=75) and Japan (n=20) completed an author-devised, 22-item survey assessing attitudes toward mental illness and its treatment, and perceptions about the role of different etiological factors. Many of the items on the survey were based on a questionnaire developed previously by Fisher and Farina (1979). Items were 5-point Likert-format, and assessed such things as the stigma associated with mental health problems ("How socially degrading are mental health problems? 1=extremely, 5=not at all"). A cross-translation of the survey instrument used with the American students showed a high degree of reliability across the two language formats.

To check for the accuracy of translation, Japanese students enrolled in American schools completed both versions of the questionnaire. No significant differences between the two versions were found.

Results

Between group t-tests were used to compare US and Japanese students' responses on various questionnaire items. The American students perceived mental health problems as more socially degrading than Japanese students (U.S. $x=2.65$, s.d.=1.07, $n=75$ versus Japan $x=3.20$, s.d.= .83, $n=20$; $t=2.11$, $df=93$, $p<.05$). U.S. students were more likely to conceal having a mental disorder because of social discrimination than Japanese students (U.S. $x=2.61$, s.d.=.98, $n=75$ versus Japan $x=3.25$, s.d.= .85, $n=20$; $t=2.7$, $df=93$, $p<.01$). Similarly, the U.S. participants were less likely to recommend that a friend with a problem go to a mental health clinic for treatment (U.S. $x=2.18$, s.d.=.99, $n=75$ versus Japan $x=1.15$, s.d.= .49, $n=20$; $t=6.5$, $df=63.8$, $p<.01$).

However, the America students were less likely to see mental health problems as a sign of weakness than the Japanese respondents (U.S. $x=3.82$, s.d.=1.1, $n=74$ versus Japan $x=2.95$, s.d.= .60, $n=20$; $t=4.695$, $df=56.6$, $p<.01$). No significant difference in extent of agreement with the biophysical etiological model was found. In contrast, American students expressed greater agreement with both the behavioral (U.S. $x= 2.6$, s.d.=.77, $n=74$ versus Japan $x=3.35$, s.d.=1.23, $n=20$; $t=2.57$, $df=23.24$, $p<.05$) and the humanistic models (U.S. $x= 2.47$, s.d.=.73, $n=73$ versus Japan $x=2.9$, s.d.=.85, $n=20$; $t=2.28$, $df=91$, $p<.05$). They voiced less agreement with the psychoanalytic model than

their Japanese peers (U.S. x= 3.05, s.d.=.92, n=74 versus Japan x=2.0, s.d.=.97, n=20; t=4.49, df=92, p<.01).

The American students saw the patient as having the more important role in determining whether therapy was successful, while the Japanese students saw the therapist as more important (U.S. x=3.73, s.d.=.86, n=75 versus Japan x=2.6, s.d.=1.27, n=20; t=3.76 df=23.8 p<.01). The Japanese students were more likely to see the cure for mental problems as being outside the individual's control (Japan x=2.85, s.d.=.93, n=20 versus US x=2.10, s.d.=.85, n=73; t=3.43 df=91 p<.01).

Americans saw greater value in thinking about the cause and solutions to emotional problems (U.S. x=1.77, s.d.=.71, n=74 versus Japan x=3.1, s.d.=.72, n=20; t=7.4, df=92, p<.01). U.S. students saw "curing" mental illness as depending less upon better medically based treatments than verbal psychotherapy (U.S. x=2.4, s.d.=.82, n=75 versus Japan x=2.9, s.d=.85, n=20; t=2.27, df=93, p<.05). Japanese students saw the cause of mental problems as more genetic than their American peers (Japan x=3.4, s.d.=.50, n=20 versus US x=2.99, s.d.=.86, n=75; t=2.05, df=93, p<.05). Japanese students reported greater recent use of drugs or alcohol to relieve emotional problems (Japan x=3.75, s.d=.97, n=20 versus U.S. x=2.15, s.d.=1.33, n=74; t=4.97, df=92, p<.01).

Discussion

As expected, there were significant differences between the US and Japanese respondents in terms of their attitudes toward mental illness. The American students were more likely than Japanese students to conceal mental disorders, presumably because of their expectation that greater social stigma is associated with these disorders. Possibly because of fears of social discrimination, they perceived mental health as more socially degrading, and were consequently less likely to recommend that a friend with mental problems go to a mental health clinic than were Japanese students.

Japanese students saw the causes of mental problems as more genetic than their American peers. This tendency may partly explain the American students' tendency to think that the patient has a more important role in curing a mental illness than Japanese students. In contrast, Japanese students think therapists have a more important role in treatment, and see the cure of mental illnesses as being largely out of the patient's control. Therefore, it is understandable that American students place greater value on thinking about the cause and solutions of mental illnesses.

It seems likely that cultural differences account for these observed differences, but we cannot actually conclude anything about the causes of these differences from this particular data. The more patients with mental illness a nation has, the more the people living there will pay attention to this problem and the more knowledge they are likely to have about the problem of mental illness. As a result, the differences observed in this study may not be due to cultural differences but rather to differential prevalence of mental illness.

Another problem with this research involved the difficulty in defining mental illness cross culturally. Every individual has their own images or definitions of mental illnesses, and these images may vary systematically as a function of nationality. When participants were asked to answer the questionnaires, they used their own definitions, so some might have focused on depression as a model of mental illness, while others might

have thought about more severe illnesses, such as schizophrenia. This may have effected responses to questionnaire items, and possibly contributed to differences between the responses from the two countries.

Another difficulty involved interpreting the finding that Japanese subjects used more drugs or alcohol than US subjects to relieve emotional problems. If there is some difference in the amount of normal use of these substances across the cultures, we cannot conclude that Japanese students use more drugs or alcohol than US students to address psychological problems. However, data shows that there is no actual difference in the amount of alcohol people generally consume per year between the two countries. However, in the USA, the sale of alcohol is quite restricted, and young adults must show ID to buy alcohol. In contrast, it is relatively easy to buy alcohol in Japan (you can get it by vending machine). So, one may surmise that young people under 20 years of age may have greater access to alcohol in Japan, and that as a there may be greater use in Japan. In addition, it is important to keep in mind that we cannot compare the data from different countries directly, because the kind of the alcohol consumed is different, and the degree of the strength of the alcohol varies across countries

Table 1: The amount of alcohol consumed per year in each nation (*1)

Year	1996	1997	1998
USA	6.5L	6.6L	6.6L
Japan	6.6L	6.6L	6.6L

The findings from this cross cultural comparison suggest that in some respects, attitudes in the U.S. are less conducive to quality care for those with mental illnesses than the attitudes of those in Japan. The fact that American students were found to see mental health problems as more socially degrading is consistent with the findings that Americans reported a greater tendency to conceal their own problems and to refrain from recommending therapy for a friend. This suggests that Americans with mental disorders may be less likely to benefit from available treatment technologies than their Japanese counterparts.

On the other hand, the Japanese respondents were more likely to see mental illness as representing a sign of weakness on the part of the sufferer. The Japanese students saw patients as having less control over the course of their recovery, and were more likely to credit therapists for positive therapeutic outcomes. Consistent with this, the Japanese respondents were less likely to adopt a behavioral or humanistic causal perspective in explaining an individual's problems in living. Both of the two models the Japanese students most endorsed, the biophysical model (especially its emphasis on genetic causation) and the psychoanalytic model, portray mental illnesses as deeply rooted and difficult to remedy. The biophysical model focuses on the centrality of medication in treatment, casting the patient as dependent on an expert's prescription for improvement. The psychoanalytic perspective emphasizes how unconscious forces largely outside of the scope of individual control govern behavior, implying that only through the efforts of an expert to translate inaccessible motives can the patient improve.

As a result of the emphasis on these causal perspectives, Japan has invested fewer resources in developing behaviorally or humanistically based treatments. Credentialing and licensing of psychotherapists has yet to be formalized, permitting poorly trained practitioners to operate freely. The work of less skilled therapists probably exacerbates the perception that cognitive and behavioral psychotherapy is of limited value in treating these disorders.

Future research should attempt to obtain a larger sample of respondents, and should strive to include a broader representation of ages and socioeconomic classes from both countries. In addition, efforts should be made to assess the reliability and validity of both forms of the questionnaires utilized with these more diverse samples.

(*1) http://www.suntory.co.jp/liquor/guide/statistics/statistics_1.html

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Printed Name/Position/Title: Catherine Chambliss, Ph.D., Chair, Psychology

Organization/Address: Dept. of Psychology, Ursinus College, Collegeville, PA 19426

Telephone: (610) 409 3000

FAX: (610) 489 0627

E-Mail Address: cchambliss@ursinus.edu

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